DOCUMENT RESUME

ED 325 748 CG 022 901

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TITLE The Professional Challenges for Counselors.
PUB DATE 85
NOTE 82p.; Chapters 12-14 of "No Longer Immune: A Counselor's Guide to AIDS" (see CG 022 897).
PUB TYPE Collected Works - General (020)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; Caregivers; Client Characteristics (Human Services); Coping; Counseling Techniques; Counselor Role; *Counselors; *Ethics; *Health Education; *Legal Responsibility; *Prevention; Well Being
IDENTIFIERS *Countertransference

ABSTRACT

This document consists of the fourth section of a book written to educate and inform those in the helping professions on how to deal with Acquired Immune Deficiency Syndrome (AIDS). The three chapters in section 4 are devoted to special issues for counselors, issues that directly affect the caregiver. They examine professional challenges to counselors doing AIDS work. "AIDS Education and Prevention" (Nancy Garfield and Rev. James Hammond) underscores how important it is that all counselors be educators and proposes specific techniques for effective AIDS prevention and education programs. "AIDS and the Duty to Warn: Ethical and Legal Factors" (Richard Green) describes the dilemma AIDS poses and the duty to warn potential victims. It clearly and concisely provides counselors with information they need to face the difficult decisions of conscience, statutory law, and ethical guidelines. "Coping With Countertransference" (Sheila Namir and Scott Sherman) discusses countertransference from an expanded view, referring to a counselor's conscious and unconscious emotional reactions to clients and the nature of the human immunodeficiency virus (HIV) spectrum diseases. It examines situational and therapist factors in countertransference and gives suggestions for confronting countertransference issues and preventing burnout. (NB)

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Section Four

THE PROFESSIONAL CHALLENGES FOR COUNSELORS

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Section Introduction

The issues raised by the AIDS crisis are not confined to people infected with the HIV. Counselors, too, have had issues thrust upon them by the AIDS crisis. This section examines professional challenges to counselors doing AIDS work.

One of the biggest questions counselors face is how they can help to reduce the continual spread of AIDS. In chapter 12 on education and prevention, Garfield and Hammond write that "if counselors wish to assist in preventing the spread of AIDS, education is the only weapon in the prevention arsenal." Chapter 12 underscores how important it is that all counselors be educators. The chapter proposes specific techniques for effective AIDS prevention and education programs.

In chapter 13, Green tackles one of the more difficult areas in the counseling profession: legal and ethical issues. From his unique position as a psychiatrist and lawyer, Green describes the dilemma AIDS poses and the duty to warn potential victims. His chapter clearly and concisely provides counselors with information they need to face the difficult decisions of conscience, statutory law, and ethical guidelines.

No Longer Immune: A Counselor's Guide to AIDS concludes with chapter 14 by Namir and Sherman, which is devoted to countertransference issues. Counseling people with AIDS is an experience unlike any others most counselors have had. Namir and Sherman write that whether a counselor's experiences "are seen as stressors, leading ultimately to 'burnout' or as opportunities for both personal and professional growth," will often depend on the counselor's awareness of countertransference issues. The authors of this chapter discuss countertransference from an expanded view, referring to a counselor's conscious and unconscious emotional reactions to clients and the nature of the HIV spectrum diseases. The authors examine situational

and therapist factors in countertransference and give suggestions for confronting countertransference issues and preventing burnout. Namir and Sherman conclude their chapter, and the book, with an honest, sensitive, and revealing look at the countertransference issues they themselves experienced during their early work with people with AIDS.

Counselors must open their hearts and help those affected by the AIDS crisis. Counselors cannot avoid their responsibility to educate, to work toward the prevention of the spread of AIDS. Counselors cannot escape the legal and ethical questions of working with people with AIDS. Finally, and perhaps most importantly, counselors cannot ignore the toll that doing AIDS work takes on them personally. AIDS brings with it great opportunities for counselor growth and development, countered by situations of depletion and despair as well. Counselors must find, for themselves, sources of both inner and outer support in order to truly embrace the notion that they are, in the face of the AIDS crisis, no longer immune.

Chapter 12

AIDS EDUCATION AND PREVENTION

Nancy J. Garfield and Rev. James Hammond

Counselors and human development specialists are in an excellent position to assist in slowing the spread of AIDS. They have not only the ability but also the access necessary to provide education and information about the human immunodeficiency virus (HIV), how it is spread, and how one can reduce his or her risks of exposure. If counselors wish to assist in preventing the spread of AIDS, education is the only weapon in the prevention arsenal—there are no vaccines, there are no antidotes, there are no cures, and there are no quick fixes.

AIDS education and prevention programs are being developed nationwide. The first programs were targeted for the gay community, and were successful in achieving a reduction of high-risk behaviors because of their audience-specificity. Primary health education programs are most successful when they have a circumscribed population with training that addresses their particular needs. Becker and Joseph (1988) found that risk reduction has occurred more often by the modification of sexual or drug-use behavior than its elimination. Longitudinal descriptions of individual behavior demonstrate considerable instability or recidivism. Fineberg (1988) indicated that although "some striking changes in behavior have occurred, especially in homosexual populations in areas with high prevalence of AIDS, educational efforts to date have succeeded more in raising awareness and knowledge about AIDS than in producing sufficient changes in behavior." Sorenson, Gibson, Heitzmann, Dumontet, and Acampora (1988) developed a prevention program for drug abusers in a residential treatment program.

The preliminary results of the 6-month follow-up show that their program increased participants' (N = 56) knowledge about AIDS and changed some attitudes that had put them at risk of acquiring or transmitting the HIV infection.

Agreement has not been reached on the content that composes adequate AIDS education because of various moral or ethical postures from which sexuality is approached; agreement has not been reached on the methodology of AIDS education in part because each educator must adapt her or his style to the task to be effective. In this chapter, a framework is presented upon which specific educational programs for AIDS prevention may be developed. This framework is based on the belief that essential elements of style or procedure must be incorporated in any AIDS education presentation, whoever the audience may be.

Themes in Successful AIDS Education

The topic of AIDS is highly charged emotionally, and it is of particular import that when presenting an educational program, counselors attend to the themes identified in this section. Both authors are trained and experienced AIDS educators, and both strongly believe that the guidelines set forth in this chapter will enable any interested person to maximize his or her ability to be effective as a communicator.

AIDS Education Should Be Appropriate

Each audience is different in important ways, some obvious, others subtle. Astute educators will be able to assess these apparent differences quickly, and be able to tailor the message to fit the receivers. For example, the educator's vocabulary needs to be modified when speaking with third graders rather than adults. Audiences composed primarily of clergy will be more interested in pastoral issues whereas audiences composed primarily of nurses will be more interested in issues of hands-on care. Some differences are less apparent though equally important. The authors of this chapter failed to recognize one such element when hosting a workshop for ordained ministers. The workshop was labeled in our community as a "liberal" event; conservative ministers did not register in large numbers.

Because our goal was to help prevent the spread of AIDS by educating ministers, and not to change the perspective from which they approached AIDS, we erred in letting our bias affect the outcome of our effort.

AIDS Education Needs to Be Accurate

AIDS is a relatively new disease that has an exceptionally high morbidity rate. Most people who contract the HIV virus will eventually fall victim to the disease. In light of the facts about AIDS, to say that AIDS is an overwhelming disease is to grossly understate the case. In one recent educational event, the male partner of a monogamous, *heterosexual* relationship of more than 20-years standing shared with those assembled that his intimate encounters with his spouse were suffering from all of the news about AIDS. Irrational as it may be, people are simply scared to death; unfounded as it may be, people are reacting in their lives, often inappropriately, based on their fears. In 1988, national attention was given to two extremes of opinion about the safety of heterosexual relationships, one published in *Cosmopolitan* stating that "there is almost no danger of contracting AIDS through ordinary sexual intercourse" (Gould, 1988, p. 146), the other in a book by Masters, Johnson, and Kolodny declaring that AIDS infections are "running rampant" in the heterosexual community (1988). Neither extreme represents the best information available, and neither is helpful in the battle against the spread of AIDS. Information being taught must be accurate; to the extent that the public becomes distrustful of information being disseminated, to that extent the public will ignore the same. Counselors have a wonderful opportunity, seldom enjoyed, to address an audience hungry to learn. Audiences must be assured, however, that what they are hearing they can trust with their lives. Instead of dismissing the potential for the spread of AIDS through oral sex as unlikely, responsible counselors and educators will be better advised, and their clients and audiences better served, to respond more truthfully to such a question: "We do not believe that AIDS is transmittable through oral sex, we have no documented cases of such transmission to date, but we simply do not know for sure; always use a condom or a dental dam." (A dental dam is a piece of latex or similar material available in varying sizes from dental supply houses and recommended for use as a protective barrier during cunnilingus and oral-anal sex.)

Some audiences will come with preconceived notions about the disease that are based on beliefs and not on facts. One example that surfaced in an event being hosted by the authors was a gentleman who stood to share with the assembled his belief that AIDS is God's punishment upon a "perverted segment of the population," and that the disease has only coincidentally spread to others. Such a belief puts an impediment in the educator's path of disseminating accurate information in a simple and straightforward fashion. No amount of logic will dislodge such a belief in many cases, so the educator is left with only one option—finding a way to work the message around the bias. "Although I may not agree with your conclusion, I hope you will agree with me that we need to use condoms if we are to prevent a further spread of this disease." To attempt to fight the battle on the grounds of someone else's belief is a mistake. It is better to take each person where he or she is and provide the most up-to-date and accurate information you can.

AIDS Education Needs to Be Articulate

The educator should assess the audience to know to whom he or she is speaking and make decisions about how much and what kind of information is to be presented. The temptation to speak on epidemiology is almost overwhelming in an AIDS presentation because such information is so informative, but it is highly inappropriate in a gathering of third graders. Third graders need to know much more basic information—what AIDS is, how AIDS is spread, what the body parts are and how each is involved, what body fluids are and which are most risky, what touching is as well as what kinds of touching are o.k. and what kinds are not o.k., whether they are at immediate risk of getting AIDS, and so forth. On the other hand, a gathering of physicians will need to know the epidemiological information, along with all of the above! Educators need to be articulate with their information. They need to operate under the assumption that their audience has limited knowledge about AIDS and its transmission. In any audience there will be people present with varying degrees of knowledge about AIDS. For example, many physicians believe that documentation of HIV status in a medical record or chart will help to prevent members of the medical community from contracting the disease. The educational fact is that all patients ought to be treated with universal blood and

body fluid precautions by all medical personnel at all times; when such precautions are taken, charting HIV status is rendered moot.

AIDS Education Needs to Be Accessible

Statements like, "This is the fourth time I've been to a seminar on AIDS, but it is the first time I've really understood that I am not at risk for AIDS by hugging someone," heard time and time again by AIDS educators, demonstrate that the messages that need to be disseminated about AIDS require more than one exposure to be learned. Information that has highly charged emotional content or import, such as the potential for dying, is often more difficult to learn. Anyone attempting AIDS education must be aware that multiple exposures are necessary for most people to learn accurate information about AIDS. There are several ways that you can encourage people to further their exposure to the information. Seminars can be planned to meet over three 2-hour sessions rather than one 6-hour session; bibliographies and other appropriate printed material can be provided to participants in educational events, free of charge if possible; sign-up lists can be arranged so that lists of people in attendance as well as lists of resources and speakers can be circulated. Networking is one way to increase the amount of exposure to the information available about AIDS. The counselor and educator not only need to provide information, they must first overcome fear, and, having provided information, motivate behavior change. Multiple exposure to the information often is required if a counselor or educator is to accomplish all three tasks.

AIDS Education Must Be Affordable

"I would have come to your gathering but I simply could not afford to take the time off from work. Even if I could have taken off from work, $75 is far more money than I have for such an event." Those are the actual words a colleague spoke to one of the authors when she was asked about the potential for carpooling to an AIDS educational event sponsored by one of the leading medical institutions in the country. When hosting an event, difficult decisions must be made about cost versus availability. No one wishes to lose money by hosting an event.

yet many people who wish to learn cannot pay. Tapping federal, state, and municipal resources is one way to work around the problem of how much to charge for an educational event. Frequently private sector resources are available to assist, not only in planning an event, but also in carrying it out. Local AIDS education groups often can provide experienced speakers without fee. Many churches and schools can tap such resources without paying. If the goal is to reach as many people as possible with information about preventing the spread of AIDS, dollars need not be a hindrance to attendance. Many people have more investment in educational endeavors for which they have to pay something, so at least a minimal fee for any event, perhaps stated as a "materials cost," is recommended.

AIDS Education Should Be Amoral

Counselors come to educational opportunities with their own values, their own ideas about right and wrong, good and evil; many counselors and educators have clear ideas about what is moral and what is immoral. Providers of information about AIDS are no exception because AIDS tends to strike at disadvantaged groups of people, many of whom are often disenfranchised. Consider for a moment that homosexuals, bisexuals, substance abusers, and infants are among those most likely to develop AIDS. If counselors and educators approach their efforts through the eyes of one moral perspective, they stand to lose whatever influence they may have with everyone who holds a differing moral stance. Instead of offering controversial opinions, educators need to center on a subject that can be agreed upon, for example, that information about AIDS needs to be disseminated.

AIDS Education Should Be Affective

"The audience was hushed as he spoke. Tears filled the eyes of many; it was a moving experience. John, a PWA, a person with AIDS, had just shared his story, and clearly many in attendance were caught up by the emotion of the moment—some perhaps even changed their outlook on PWAs because of John's willingness to share." Educators working in the field of AIDS for any length of time over the past several years have no doubt been privileged to participate in an event such as the

one described above—the moving appearance of a PWA to tell his or her story to an audience of generally mixed sympathy. One such PWA even spoke eloquently to his audience, telling those gathered they did not need to protect him or his feelings as they asked him questions. "I'm a big boy," he told his tentative audience. "I can take it." As moving as those talks may be, how many educational events *require* the presence of a PWA? There is a difference between featuring a speaker because he or she has something to add, and simply mollifying voyeuristic inclinations. The added benefit that comes to an AIDS presentation by providing a vicarious experience of the disease is highly questionable except under the most unusual and demanding of audiences. It is almost always costly to a PWA to make a personal appearance, and although it may be loving on his or her part, how loving is it to him or her?

Instead, educators can help to make their own presentations affective by teaching people to keep sex erotic and exciting! Many men and women seem to believe that sex can no longer be fun if they must be responsible, if they must plan, and if they must use a condom or a dental dam. Counselors and educators can teach people that safer sex practices can actually heighten their lovemaking experience. Teasingly, the partner can offer to assist in placing a condom; affectionately, more touching can be added to the script; caringly, the couple can simply become more conscious of new ways to please. Paying attention to safer sex (condoms, dental dams, and spermicides) can be presented as truly loving behavior.

An equally important part of amorous AIDS education is the openness and accessibility of the presenters to all in attendance. It is important to recognize that persons in your audience will need to be able to question you, to approach you for clarification, perhaps even to get to know you. You are asking many in your audience to change life views as well as behavior; if you are to be successful, you must be available. That kind of personal availability comes only through a willingness to reach out and love others through your educational endeavors.

AIDS Education Should Be Anecdotal

Although it is generally not necessary to have a person with AIDS in attendance at an educational event, it is important to personalize the event for those participating, to make it real.

One way to personalize the data is to invite people whose lives have been touched by AIDS, from hands-on caregivers to parents and relatives of PWAs. One most impressive presentation was the mother of a person with AIDS speaking to a group of clergy. She told of a minister refusing to make a house call on her dying son, and of another who did visit, only to give the son a lecture on sin. Professionals experienced the insensitivity of their beliefs by being brought face to face with their behavior. The more the lives of people can be touched, the more the message gets through. Slide shows are great, videos are superb, but neither is a substitute for first-hand reporting from people actually involved—one presence is worth a thousand words!

AIDS Education Should Be Apologetic

Apologetics in the theological sense means the making of a reasoned defense on intellectual grounds for one's beliefs. AIDS educators must be trained, willing, and desirous of being apologists for AIDS education. Many people simply don't want even to hear about AIDS; they will resist with every ounce of their being learning what they need to know for their own health and well-being. Some grudgingly assert that AIDS education is important, but only for others—the ones likely to become infected. AIDS educators and counselors need to lobby at every opportunity with officials at every level for the presentation of effective programs. If counselors and educators go to a house of worship, they should speak with the leader about an AIDS education program for persons in each age group. If they have children in school they should speak to the administration about the need for teachers to be trained and equipped to do AIDS education in the classroom. Counselors and educators can make appointments with the elected legislators in their district and impress upon them the need not only for programs but also for funding. Write letters; send telegrams; make phone calls; take people to lunch.

AIDS Education Should Be Astonishing

Few topics that challenge the abilities of an educator have as many built-in aids as does AIDS! If one wishes to "hook" an audience, one need only get up and say, "if you don't listen to what I have to say today, your inattention may kill you." One

can make use of the startling statistics that this disease presents: 100% of persons with AIDS are likely to die from their disease; infection rates are nearly doubling each year; use of a condom decreases your chance of contracting AIDS on any given occasion by a factor of 10. Any of the above attracts the attention of audiences. Along with the sensational figures, there is some solace and comfort. The number of medical personnel who have seroconverted due to inadvertent needle-sticks is remarkably well below one half of 1%—good news not only for persons employed in the medical field, but for all. (This low seroconversion rate supports other data suggesting that AIDS is hard to get, even when one is inadvertently inoculated with infected fluid or tissue.) There is no evidence to suggest that casual contact vectors AIDS—people won't get it from living in the same house with a PWA. Mosquitoes do not spread HIV. Whether the educator snags his or her audience with the good news or with the more sensational news, the point is simple—the disease AIDS is filled with opportunities to assist the educator to do the job. Use eye-catching data to drive home the message; rely upon the high levels of affect generated by the material to motivate audiences. Structure your educational event to maximize the advantages inherent to the materials you are trying to teach. For example, if you want to wake your audience up, take out a condom, blow it up, pass it around, put it over your head, do whatever it takes to help people remember your message: Condoms are to be used!

AIDS Education Should Be Authentic

The key to authenticity is in the speaker. Even the most truthful data will go unbelieved by an audience that does not trust the presentor. Therefore, counselors and educators must find a way quickly and effectively to gain their audience's respect if they wish life-changing behavior to result from their presentations. Showing vulnerability is one way to foster people's acceptance and trust. Educators can share stories about how AIDS has affected their life, or how they have intervened in the life of another. One AIDS educator was talking with a young girl and her boyfriend about safer sex when she discovered that the couple's name for his penis was "Freddy." To explain the importance of using condoms, she said, "Put a hat (condom) on Freddy each time you have sex." Her intervention

was effective not only with the young couple in terms they could understand, but also gave her a story to share in future educational events. Cicero said that a good speaker is a good person who speaks well. AIDS educators who are effective will fit his model—they will be good people, genuinely concerned about others, who present their message with authenticity.

AIDS Education Should Be Awesome

Many workshops are filled with too much free time; when professionals attend an educational experience, the presentors need to remember that professionals are for the most part busy people who do not take well to having their time frittered away. Counselors and educators cannot hurt themselves or their workshops by overscheduling; the worst thing that can happen is that the workshops will run a bit late. Plan a variety of presentations to keep people from becoming bored. If you, as educator and presentor, take your message seriously, the chances are that those in attendance will as well, whether they agree with you or not. Extemporaneous remarks offered by even well-informed persons do not receive the kind of favorable feedback that a thoroughly prepared presentation does. A higher level of learning is required to attain the goal of motivating people to action in the prevention of the spread of HIV. It is one thing merely to teach, another altogether to motivate!

Methodologies for Presentations

In this section specific suggestions about methodologies, as well as some potential pitfalls in preparing an AIDS education program are discussed. Each educator should adapt the material that follows for best use in his or her presentation.

AIDS Educators Need to Use All Available Media

Some of the most successful methods of conveying to an audience the pain inflicted by AIDS can be found in several high-quality videotapes. No one wishes to attend a workshop only to be placed in front of a television all day, but one or two carefully chosen tapes of modest length can do wonders for

getting a difficult message across. It is necessary to measure the audience and choose such tapes with care, and to pay attention to dated material as new findings and new statistics obtain, but when tapes of high quality are used with care by the educator, the results can be very gratifying indeed. In addition to the video medium, audiotapes, books, pamphlets, slides, overhead gels, and printed handouts can help make a workshop successful. If the educator does some basic research ahead of time, he or she will discover far more material available than can possibly be used in any given presentation. Sources to tap are our local and state health departments, private community agencies devoted to AIDS, libraries, hospitals (especially teaching hospitals), and in some communities, churches. Some denominations have excellent educational packages designed for group work already prepared for educators wishing to work with smaller numbers of people.

AIDS Educators Need to Pay Attention to Techniques of Delivery

Most educators need to be reminded that how something is said can spell the difference between being heard and not being heard, often literally. Is the sound system sufficient for the crowd? Can the slides be seen? Are there enough televisions so that everyone present can see and hear the selection of videotapes? Why work so hard to stage an educational gathering and then fail to meet the audience's human needs to be able to see, to hear, and to take notes? Counselors have a great deal to offer as educators about the need for the prevention of the spread of AIDS; they should be prepared to try to do all in their power to accomplish the goal. The cost of failing to get the message across is high, unacceptably high, if the reason is the failure to pay attention to simple details.

Educators May Benefit From Working in Small Groups

The benefits from working in smaller groups of people are already well documented and well known to most educators and counselors—more people become more involved, each person is heard, individuals' questions can be addressed, resistance to process is easier to deal with, and so forth. Working with small groups, however, does require prepared personnel; with

a little advance preparation facilitators can help in AIDS presentations even if they are not thoroughly knowledgeable about AIDS. The successful small group experience will be an open-ended one that gives each participant a chance to voice his or her own opinion while also learning about others'. Experience has proved that it is always best to give some rudimentary facts prior to sending people into small groups to grapple with hard questions. Small group work is best midway in a workshop, after participants have had a chance to come on board with the topic but well before wrap-up, so that issues generated in the small groups can be shared and discussed. Educators who wish to use the small group format need to plan what happens so that control of the event is not lost. This can be done through proper staffing and proper tasking. Small groups have the immense advantage of personalizing the educational experience, but the disadvantage of being time-consuming.

AIDS Education Benefits From Experiential Techniques

People learn best by doing, not by looking, observing, and listening. If a presentation about AIDS is given to a group of counselors, it is well to have participants practice counseling techniques. If a presentation is given to a group of teachers, have the teachers get up and teach for a time something they've learned. If the proper use of condoms is being taught, do a "hands-on" presentation where the condoms are distributed, the packages opened, and the contents felt and observed first-hand. One of the authors was disturbed to watch a nurse give a demonstration on HIV prevention techniques in the work place, be it hospital or doctor's office, that included the drawing of blood without the recapping of needles. The nurse asked for a volunteer so that she could demonstrate the techniques she was recommending, then proceeded to draw the "victim's" blood without the approved standard procedure of wearing rubber gloves! Her message was lost because she failed to practice what she was teaching. People learn by doing; providing opportunities for them to do so helps them learn.

AIDS Educators Must Not Be Bashful About Repetition

Research has demonstrated that people need to be exposed to information about AIDS on several occasions before the mes-

sage begins to take. Most educators will have only one opportunity to address any given group, so it is necessary to present the same data from several perspectives. It is worth the risk of being called a repetitive speaker if the audience remembers what was presented. If educators tell the audience, "AIDS is preventable," as they begin the workshop, as they come back from a lunch break, and several times just before they leave, some people may be angry, but "AIDS is preventable" will be on the tips of their tongues and forged in their minds. If people remember that AIDS is preventable they will know enough to find the answers they need. Repetition is the key to teaching that "AIDS is preventable!"

Pitfalls To Avoid in AIDS Education

It is important to identify clearly any roadblocks that might obstruct the goal of preventing the spread of AIDS through effective educational programs. The following should be considered as potential problems.

Jargon as an Enemy to Effective AIDS Education

The first concern is the use of jargon, especially in heterogeneous audiences. If counselors are speaking to an audience full of MDs they can easily infer that most will at least understand the terms, but many lay people will trip over HIV, ARC, AZT, antibody, PWA, PWA, and even perhaps such terms as "seropositive." How many people in an average audience will understand that AIDS is an acronym, standing for the formal name of the syndrome—acquired immunodeficiency syndrome? Although the technical term is condom, some people use the word "rubber" whereas others prefer prophylactic or sheath; youngsters, particularly, are often confused by the multiplicity of terms and are not always certain just what is being talked about unless counselors and educators overcome their embarrassment and make themselves crystal clear. With all audiences, but especially with young people, the more formal terminology should be used when discussing the sexual aspects of the spread of AIDS. A meeting of the minds needs to be held early on to ensure that all understand the terms you are using. One excellent icebreaker for gatherings of young people

is taking the time to list all of the various words they use for genitals. Unless counselors are clear to the audience, they may not know what is being talked about and the message will be lost.

Question Your Assumptions

"Physicians will be well informed about AIDS." "People have seen a condom and know how to put a condom on an erect penis." "The average monogamous couple's sex life is unaffected by AIDS." These assumptions and others like these are not necessarily correct and can cripple a presentation for two reasons: first, inaccurate assumptions can keep counselors and educators from presenting vital information that people may need to know in order to understand AIDS prevention; second, assumptions can keep counselors and educators from hearing what others are saying. By way of example, presenters at a gathering where AIDS information was being presented to a large number of heterosexuals, most of whom live in monogamous relationships, centered their program on the sexual vectors of AIDS; in doing so they missed an opportunity to uncover significant pain in the lives of some people in attendance who felt they were at risk for HIV infection due to other vectors (transfusions, blood splatters, and sexual relationships with intravenous drug users). AIDS educators should not make any assumptions.

Avoid Statistical Boredom in AIDS Education

Although AIDS is a source of interesting data, there is a danger in presenting too many statistics. For each statistic to be presented, educators should assess whether their audience needs to know this fact. Some audiences will need to know facts—by way of example, medical personnel can benefit from learning about the low seroconversion rate from needle sticks, mentioned earlier. Most audiences, however, do not gain from the presentation of statistics and may actually be hurt. At one presentation where the audience was given epidemiological data on the prevalence of HIV infection rates by state, some in attendance commented that "We don't have a problem here in Kansas, so we don't have to worry about precautions." The presentation of statistics gave participants the misleading notion

that AIDS exists only in New York City or in San Francisco. In reality AIDS exists in every state in the country. It is a mistake to present too much statistical data in AIDS education events because such data are often boring and sometimes downright misleading. Data should be used only on a "need to know" basis.

Pay Attention to Audience Reticence in AIDS Education

Although giant strides have been made over the past generation in opening communication among people on issues sexual, many people are still uncomfortable talking about "private" issues in public. Some people even feel repelled when formal medical terminology is used, never themselves finding the need to use the words "anus," "vagina," or "penis." AIDS education counselors and educators must find ways to make talk about matters sexual commonplace, to look for ways to help people feel comfortable talking about things heretofore often unmentioned. It takes all of the interpersonal skills that counselors and educators can muster to find ways to open the avenues of conversation, to enable people to talk about subjects for years considered forbidden in polite society.

What They Need to Know

When we talk about providing AIDS education we are really discussing how to help people prevent themselves from becoming infected with the HIV virus and learn the facts about the course of the infection. There is some basic information that needs to be included in every AIDS HIV educational program. The data change so rapidly that it will be important to contact local AIDS support agencies, the county or state health department, or the Centers for Disease Control to obtain the most current statistical and medical information. The *MMWR, (Morbidity and Mortality Weekly Report)*, provides updates on health guidelines and recommendations for programs such as the "Guidelines for Effective School Health Education To Prevent the Spread of AIDS." *The Journal of the American Medical Association* and *The New England Journal of Medicine* contain the most current research articles about AIDS and HIV infection.

People attending AIDS programs need to know that the routes of HIV transmission are blood and body fluids (primarily

semen and vaginal secretions). At-risk behaviors are sharing intravenous needles and paraphernalia, and having unprotected sex. Sadly, babies born to a mother who is HIV-positive are also at risk. Many people are afraid that AIDS is transmitted by touching and hugging, sharing kitchen utensils, or being in the presence of someone known to be HIV-positive. AIDS is not transmitted through such *casual contact*.

When talking about safer sex, counselors and educators should include the following advice. The way to be safest is to be abstinent. If abstinence is not an option people wish to choose, they should avoid high-risk behaviors such as having sex with multiple partners, or with people who have or have had sex with multiple partners. During intercourse, condoms containing a spermicide with nonoxynol-9 should be used. Research seems to indicate that the spermicide nonoxynol-9 further reduces the risk of contracting the HIV. Practices that may injure body tissues, for example anal sex or rough vaginal sex, should be avoided. Oral-genital contact should be avoided unless the man is wearing a condom or a dental dam is used. Although many caution about open-mouthed, intimate kissing, recent research (Fox, Wolff, Yeh, Atkinson, & Baum, 1988) seems to indicate that this is less of a risk than first thought.

Counselors and educators can suggest that there are many ways to be intimate and to be safe in addition to protected intercourse. Mutual masturbation can enable partners to reach orgasm and be less at risk if they avoid sharing of semen or vaginal secretions. Social kissing and body massage, frotage (the rubbing of bodies together), and hugging are other ways to increase intimacy. Most important, counselors can encourage their audience or client to talk with their partners about sex and intimacy and explore what is arousing, and what new safe ways they can find to enjoy being together.

People need to be taught about how to use condoms. In addition to the information provided here, there are several books about condoms that are useful (Brenman, Knutson, & Reed, 1987; Everett & Glanze, 1987). Only latex condoms should be used because the natural condoms are not uniform in thickness. A condom is to be unrolled onto an erect penis prior to any contact with the genitalia of the partner. It should be unrolled all the way to the base of the penis, allowing 1/4 to 1/2 inch at the tip or end for ejaculate. After the man ejaculates he should hold on to the condom and pull out while the penis is still hard. The condom should be discarded in a way that no

one will be in contact with the semen. A new condom should be used each time one has sex. Petroleum-based lubricants, such as petroleum jelly, should not be used; such lubricants can cause premature deterioration of a condom. Condoms should not be stored for a long time in a wallet or purse because they may develop little holes. (Several companies are now selling hard cases in which to carry condoms, the use of which may alleviate the problem.) Condoms should not be left in places of extreme heat such as a glove compartment. The expiration date on the box of condoms should be checked when purchasing them because they become less reliable as they age. Condoms with nonoxynol-9 are preferable and additional nonoxynol-9 spermicide should be used in the condom.

Safer sex for women in lesbian relationships includes protection from blood (including menstrual blood) and cervical and vaginal secretions. Cunnilingus is risky unless one is sure her partner is not HIV-positive, so the use of dental dams is recommended.

People attending education programs will want to know if they have placed themselves at risk in the past. They will want to know about "the HIV antibody test." The test was designed to assess the safety of the blood supply for transfusion practices. It indicates if there are HIV antibodies in the blood, not if someone has AIDS. The test is not 100% accurate. A small percentage of the time the test gives falsely positive or negative results (Myer & Panker, 1987). The accepted practice is to do a screening test, such as the ELISA (enzyme-linked immunosorbent assay) and, if the results are positive, to do a confirmatory test, most often, the Western Blot. The results of the test provide information about one's antibody status at that particular point in time. The test is most apt to be able to report antibody status at a time of no less than 2 weeks after the at-risk behavior, although it may take as long as 6 months for the test to diagnose a positive antibody status. It is important for counselors and educators to make clear that there is no test, at this time, that will provide immediate information about recent risky behavior.

The question of who should be tested is a difficult decision and has many ramifications. People who have been diagnosed HIV-positive have experienced discrimination that includes loss of job, insurance, and home. Alienation from friends, family, and co-workers also occurs. Before deciding to be tested, persons need to be aware of the possible psychological and social

legal consequences of the test. The authors discourage the practice of HIV antibody testing unless there is a clearly indicated medical reason for it. An example of a clearly indicated medical reason is establishing the etiology of neurological symptoms such as memory deficits, gait irregularity, psychomotor retardation, and dementia. Although some people believe that everyone should know his or her antibody status, others (including the authors of this chapter) believe that such information gives people permission to be less careful. Whether those concerned are practitioners who come into contact with blood or body fluids on the job, or simply people who wish to use a negative HIV status to avoid safer sex practices in a casual relationship, the scientific reality is that knowledge of HIV status is not a prevention technique or even a prevention factor. The recent development of experimental protocols for the preemptive administration of AZT and other AIDS drugs to persons at high risk makes each individual's decision even more personal. The efficacy of these experimental protocols has yet to be demonstrated, and the associated side effects of such prophylactic treatment can be severe.

The diagnosis of AIDS is made on the basis of a number of clinical symptoms. These illnesses may include, but are not limited to: Kaposi's sarcoma, HIV encephalopathy, histoplasmosis, non-Hodgkin's lymphoma, HIV wasting syndrome or pneumocystis pneumonia. A person may meet the CDC case definition for AIDS and not have a positive HIV test. In providing education and information about AIDS, counselors and educators must be careful not to diagnose or to give that impression. Whenever possible, counselors and educators should have the name and phone number of the AIDS community service organization and the county health department available to share with audiences or clients should they wish further information.

Finally, counselors and educators must be aware that in talking with people about AIDS education and prevention, they must discuss that a diagnosis of HIV-positive or AIDS affects more than the person with the diagnosis: the family and significant others of the infected person will be affected by the diagnosis as well. Both the diagnosed patient and his or her family will experience depression, rage, and other emotions. When educating, counselors must sensitize all to assist those dealing with this horrible illness to provide as much love and support as possible. Only as counselors work together to provide

education and support can there be any hope of preventing the spread of AIDS.

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Chapter 13

AIDS AND THE DUTY TO WARN: ETHICAL AND LEGAL FACTORS

Richard Green

> *All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret.*
>
> Hippocratic Oath

The uniqueness of AIDS, fatal and sexually transmitted, provokes an unprecedented legal and ethical dilemma. Compounding this combustible mix is the additional, incendiary component whereby most persons with the syndrome are members of stigmatized social groups.

The central ethical and legal dilemma facing the health care professional with an HIV-infected patient is best serving the needs of that patient while concurrently serving the needs of others. As the AIDS epidemic escalates, with both cure and prevention seeming remote, public clamor for protection affects the private anguish of the infected. Caught between these poles is the conscientious psychiatrist, psychologist, counselor, or social worker.

Under the common law (laws that evolve from court rulings rather than from legislatures), a person generally owed no duty to control the conduct of another, nor warn those endangered by such action (Restatement 2d Torts; Prosser, 1971). However, an exception to this absence of duty has been carved out where the person stands in some special relationship to either the person who could be controlled or to that person's foreseeable

victim (Restatement 2d Torts, §315–320). That the physician, therapist, or counselor does stand in a special relationship with the patient is well established: "... a special relationship exists between the actor [therapist] and the third person [patient] which imposes a duty upon the actor to control the third person's conduct" (Restatement Section 315 (a)). With this principle as backdrop, the stage is set for major ethical and legal issues that confront the professional whose patient has AIDS. The dilemma pits the tradition of patient confidentiality against the hazard to a nonpatient.

Case Law

Although it is popularly believed that information communicated by a patient to a physician has always been confidential (or privileged), such protection is a relatively recent legal development. Despite the Hippocratic Oath admonition, there was no prohibition under the common law to communicating medical facts about a patient without the patient's consent. Indeed, it was long after the common law established a legal basis for confidentiality between attorney and client that any statutory provision was established for physician-patient privilege. (A cynical view of this progression is that the common law, promulgated by the legal profession, was concerned more with its professional interests than with those of physicians.) With the advent of psychiatry and other professional services directed toward the amelioration of emotional distress, newer professions sought and achieved comparable patient privilege. Thus today, patients (often called clients) of psychologists and clinical social workers, plus those of marriage and family counselors, may also hold privilege. In California, statutory confidentiality is provided for physicians, psychologists, clinical social workers, and marriage, family, and child counselors (Sections 990–1018, California Evidence Code). The holder of the privilege is the patient. Generally this means that unless the patient agrees to break the confidence, the health care professional may not. Exceptions to this privilege exist, however.

Precedent-setting court cases underscore the professional's responsibility to third parties (persons other than the professional and the patient), despite statute-created privilege. The

seminal legal case establishing a psychotherapist's duty to warn, in violation of confidentiality or privilege in California, is *Tarasoff v. Regents of the University of Southern California*. There the court ruled that a therapist has a duty to use reasonable care to warn a foreseeable and identifiable third party against a serious threat of danger by the therapist's patient. "The protective privilege ends where the public peril begins" (17 Cal. 3d 442). The *Tarasoff* court held: "[D]efendent therapists cannot escape liability merely because (the victim) herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that this patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim . . . The discharge of this duty may require the therapist to . . . warn the intended victim . . . or to take whatever steps are reasonably necessary under the circumstances" (17 Cal. 3d 431).

Tarasoff has been codified in California Evidence Code (CEC) §1024. "There is no privilege . . . if the psychotherapist has reasonable cause to believe that the patient is of such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger." The explanatory comment following this exception to confidentiality states, "Although this exception might inhibit the relationship between the patient and his psychotherapist to a limited extent, it is essential that appropriate action be taken if the psychotherapist becomes convinced during the course of treatment that the patient is a menace to himself or others and the patient refuses to permit the psychotherapist to make the disclosure necessary to prevent the threatened danger" (CEC at 140).

Even before *Tarasoff*, the duty to warn a potential victim in another medical circumstance had a precedent, a circumstance relevant to AIDS. In 1920, in a case involving syphilis, the Supreme Court of Nebraska ruled that the information given to a physician by his patient, though confidential, is given subject to the understanding that, if the patient's disease is found to be dangerous and so highly contagious or infectious that it may be transmitted, the physician may disclose the information to others to prevent the spread of disease (*Simonsen v. Swenson*, 1920). Other, more recent court examples reinforce the physician's liability for both not diagnosing and reporting disease (*Hofmann v. Blackman*, 1970; *Wojcik v. Aluminum Co. of America*, 1959).

A fetus or child, not just an adult, may be a foreseeable victim. Because at least half of all fetuses gestating in an HIV-positive mother are born HIV-positive, this rule is especially salient. The child becomes a "second order" foreseeable victim when its mother is exposed to the virus. California case law has extended liability to the children of "first order" victims. In *Hedlund v. Superior Court* (1983) a mother sitting with her child was shot by a psychologist's patient. The child, witnessing the attack, allegedly suffered emotional injuries. The court held that the duty the therapist owed to the woman extended to her minor child because the risk of harm to the child was foreseeable—the child was indentifiable as a person who might be injured if the patient attacked the woman.

With specific regard to AIDS, individual case law has been transformed into statutory formality. California law protects the physician who elects to warn. "No physician and surgeon who has ordered a test to detect antibodies to the probable causative agent of acquired immunodeficiency syndrome and who has the results of the test shall be held criminally or civilly liable for disclosing to a person believed to be the spouse of a patient that the patient has tested positive . . . ." (Deering Health and Safety Code, 1982). Thus no privilege exists regarding disclosure to a spouse. However, spouses, under all state laws, must be of the opposite sex. What of a steady same-sex sexual partner? What of a nonspouse, live-in opposite-sex partner? Or other, more casual partners at risk?

Patients themselves may disclose their HIV status to the state. Then, the state may contact a sex or drug partner: ". . . (a) any person receiving a test for the presence of antibodies to immunodeficiency virus (HIV) may disclose the identity of any sexual partners . . . to the county health officer . . . (c) The county health officer may alert the sexual partners . . . about their exposure, without disclosing any identifying information about the individual making the disclosure . . . ." The same rule applies to those who share the use of hypodermic needles (California Health and Safety Code West, 1988).

What if the physician does not warn? California Civil Code (West, 1988) holds that a psychologist or psychiatrist is not liable for *failing* to warn or protect a victim from a patient's behavior except "where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably-identifiable victim or victims." Thus the professional must determine what constitutes a "serious threat." Does such a threat

include the stated intention by the patient to continue sexual intercourse with an identified partner? And what of the patient with rapidly changing partners?

To keep the AIDS dilemma in perspective, we should note that psychotherapist-patient privilege is not absolute, even in situations involving medical risk to others. If a patient sues a therapist for malpractice, privilege is lost (California Evidence Code §1004). In insanity or competency hearings, privilege is compromised (C.E.C. §1004). If the psychotherapist is sought to aid in the commission of a crime or tort [a private or civil wrong, other than breach of contract, for which the court will provide a remedy in the form of an action for damages (Black's Law Dictionary, 1979)], there is no privilege (C.E.C. §997).

Professional Societies

Health care societies have also set HIV reporting guidelines. The American Medical Association (AMA), in issuing its ethical guidelines (AMA, 1987), stated that confidentiality is "absolute" until it "infringe(s) in a material way on the safety of another. . . . Those who are not infected . . . are entitled to protection. . . ." Responding to its perception of public health needs and the role of confidentiality, the AMA stated that "[a] sound epidemiologic understanding . . . requires the reporting [on an anonymous or confidential basis to public health authorities] . . . of those who are confirmed as testing positive. . . ." The AMA addressed physicians practicing in jurisdictions where reporting is not mandatory. "The physician should attempt to persuade the infected individual to refrain (from risk activities) . . . when persuasion fails, authorities should be notified. . . ." In the event that the physician knows of a specific potential victim, the AMA asserts "a physician may have a common-law duty to warn . . . ."

On the other hand, the AMA (1987) acknowledges that notifications may be prohibited by statute. In that case the AMA endorses legislation that both provides a method of warning unsuspecting sexual partners, and protects physicians from liability for failure to warn. It also establishes standards for informing public health authorities and presents guidelines for authorities when they trace unsuspecting sexual partners. The AMA has called for legislation that would grant immunity to

physicians who either notify third parties or choose not to, because the risk is deemed by them to be inconsequential. Disclosure is permissible "... with the reasonable belief that ... the information will avoid or minimize an imminent danger to the health or safety of the patient or any other individual ... when released ... to health care personnel ... in order to assist the patient or to protect the health of others closely associated with the patient." Furthermore, the physician may disclose "after counseling the infected individual to consent to the disclosure to the spouse or other sexual partner .... (Then) the attending physician may elect to notify the spouse or other sexual partner of the infected individual. A cause of action will not arise from any such notification. (On the other hand), there shall be no duty on the part of the attending physician or other health care provider to notify the spouse or other sexual partner of an infected individual, (when the physician deems the risk inconsequential) and a cause of action will not arise from any failure to make such notification."

The AMA provisions straddle the horns of the physician's dilemma. When the physician believes that the partner should be warned, the physician is protected. However, when no warning is given, because the physician does not diagnose the risk, the AMA position is similar to current California law. The physician would remain protected. A successful malpractice action for negligence in failing to diagnose might follow, however.

Infected physicians have also been addressed in AMA guidelines. The sick physician is directed not to engage in patient care that creates a risk. If a risk does exist, disclosure of the physician's seropositivity to patients is deemed insufficient; the physician must cease risk contact. However, if the physician poses no risk, disclosure is not warranted. Prior to the physician making that determination, however, the AMA recommends that the afflicted physician disclose the seropositive status to colleagues for their consideration of any risk posed.

The American Psychiatric Association (APA) has also issued guidelines on confidentiality. "Psychiatrists should not discuss their patients' care, (but) in cases involving imminent danger to others, psychiatrists must balance their duty to protect patients' confidences against their responsibility to members of the public at risk" (APA, 1987).

The APA policy statement stresses that "... any breach of confidentiality should be a last resort ...." Recognizing that

APA policy may conflict with law, guidelines suggest that "where conflict exists, attempts should be made to modify laws in accordance with the principles expressed herein."

At the onset of a psychiatric evaluation, according to the APA, when suspecting that a patient is HIV-positive or is engaging in behavior that is known to transmit HIV, the psychiatrist should inform the patient of the limits of confidentiality (a psychiatric "Miranda" warning). When the psychiatrist deems that there is a risk to third parties, the psychiatrist should first advise and work with the patient "either to obtain agreement to terminate (the) behavior . . . or to (agree to) notify identifiable individuals who may be at continuing risk . . . ." If the patient rejects this agreement, "it is ethically permissible for the physician to notify an identifiable person whom the physician believes to be in danger . . . ." (APA, 1988).

The APA also issued interim guidelines on handling HIV infection in outpatient services. HIV testing should be performed on a case-by-case basis with informed consent when medically indicated. The responsible psychiatrist should disclose the information (about HIV infection) to appropriate staff only after discussions with the patient, when the psychiatrist determines that appropriate treatment of the patient requires such disclosure. If a patient known to be HIV-infected engages, or threatens to engage, in behavior that is known to transmit HIV disease, the psychiatrist shall assure that, in addition to education, appropriate clinical steps are taken to attempt to modify the behavior (APA, 1988, October 7).

When should physicians recommend or request that a patient be tested for exposure to HIV? The California Board of Medical Quality Assurance in its guideline issues in August, 1988, urged that seven categories of patients "should be routinely counseled about and tested" for HIV. These include men who have had sex with men, hemophiliacs, persons seeking treatment for sexually transmitted diseases, persons with a history of intravenous drug use, women of childbearing age and having identifiable risks for HIV infection, prostitutes, and persons from geographic areas where heterosexual transmission of HIV is common. Physicians should also consider HIV testing with persons undergoing evaluation for clinical signs and symptoms compatible with HIV infection, and for persons who received blood components or transfusions between 1978 and 1985. Thus, the physician who plays ostrich and does not en-

courage testing may be vulnerable to violation of professional guidelines. However, whether a patient falls into one of these seven categories may not be readily apparent.

The APA has addressed the problem of unidentifiable third parties who may be at risk, that is the transient sexual or drug partner of a patient. "It is ethically permissible for a physician to report to the appropriate public health agency the names of patients (who are) HIV-infected and whom the physician has good reason to believe are engaging in behavior which places others at risk. . . ."

Discussion

Thus, professional conduct, to be safe, is defined by these statutes and guidelines. But professional conduct, to satisfy the professional's concerns for ethical conduct at variance with statutes or guidelines, may pose a personal dilemma. Statutes and guidelines can, at times, be compromised in spirit, if not in letter. But professionals who flaunt the law or their professional society guidelines risk legal sanction or loss of licensure.

In mandating the reporting of high-risk behavior, the duty to warn may be counterproductive, however. Psychotherapists and counselors cannot deal with matters unknown to them. A basic psychiatric principle is that "every person, however well motivated, has to overcome resistances to therapeutic exploration. These resistances seek support from every possible source and the possibility of disclosure would easily be employed in the service of resistance" (Goldstein & Katz, 1962). As another forensic behavioral scientist noted, "It is clearly recognized that the very practice of psychiatry vitally depends upon the reputation in the community that the psychiatrist will not tell" (Slovenko, 1960).

Moreover, the historical alienation between psychiatrists and homosexuals is an additional dimension of concern here. Psychiatry led the public perception of homosexuality as a mental disease, and was, for decades, dedicated to the cure of the homosexual's affliction (Bayer, 1981). Many psychiatrists remain convinced that homosexuality is an illness. Thus, the profession has hardly established itself as a trusted ally among the gay community. The majority of homosexuals, not moti-

vated to reorient to heterosexuality, have historically not consulted psychiatrists. The likelihood is remote, then, that they would seek contact under a system in which their potentially most damaging personal revelation was not confidential. Consequently, the highest risk group in the United States for which reporting could be expected to protect others have entrenched biases against communicating with those professionals who are in a position to protect others.

Issues of AIDS reporting are distinguishable clinically and socially from other sexually transmitted diseases (STDs) in which reporting has been held to be the responsibility of the patient or physician. Traditional STDs were not generally identified with stigmatized minority groups. Although the diagnosis of syphilis, and later gonorrhea, carried stigma during a period in which premarital sexual abstinence and marital monogamy were expected, the stigma that attached to violation of these standards was not as substantial as the historic opprobrium attached to homosexuality and intravenous drug abuse. Nor were the heterosexual sexually active singled out for blame for the spread of a fatal disease.

With consequences of AIDS infection higher than those with syphilis in the pre-antibiotic era (many infected persons were spontaneously cured, and those whose disease was progressive did not die for about 20 years) (Clark & Danbolt, 1955), infection with the AIDS virus may be uniformly fatal. Thus there is greater risk of stigma to the infected person when that person is publicly identified, but there is also greater medical risk to the uninfected person if their risk vulnerability is not communicated.

Recent court rulings regarding liability for spreading a sexually transmittable disease have relevance for the communication of AIDS. A New York court ruled that a woman could seek compensatory and punitive damages from her former husband for his alleged transmission of genital herpes. The court held that the husband had an affirmative legal duty to disclose to his wife. Furthermore, the sexual partners need not be married for responsibility to attach. In 1984, the California Supreme Court held that a woman can maintain an action for "damages for severe injury to (her) body, which allegedly occurred because of (the man's) misrepresentation that he was disease-free" (*Kathleen K. v. Robert B.*, 1984). Infection by the AIDS virus, instead of the genital herpes virus, does not seem distinguishable for instituting legal action.

Should therapists require that their patients be tested if the therapist believes the patient to be of a high-risk group and engaging in high-risk behavior? A major damage award may await the psychiatrist who fails to predict a patient's dangerousness from contagion. A 1.4 million dollar judgment was upheld by the highest court of Delaware after it was held that a psychiatrist should have foreseen with medical certainty that a former patient would commit a dangerous act (*Venkataramana Naidu v. Ann D. Laird*, 1987).

Involuntary AIDS testing has precedent. In September 1988, in California, the governor signed a bill allowing courts to determine when a person *charged* (not convicted) with sexual assault may be ordered to undergo HIV testing when the alleged victim so requests (Sexual Assault Bill, SB 2643, 1988). California's Proposition 96, passed by voters in 1988, extends testing because of the alleged victim's fears of transmission via sweat and saliva, and not only blood and semen.

California is not alone in requiring AIDS testing in some circumstances. Illinois has an involuntary or nondisclosed AIDS testing program. There, physicians may test their patients without the patient's knowledge. Although opposed by the Illinois Department of Public Health, and the Chicago Health Department, it was supported by the Illinois State Medical Society.

Thus, the trend is toward limited or no confidentiality for HIV-positive patients. Beyond, what is hoped, the passing scope of the AIDS epidemic, will this shift undermine a major feature of the traditional doctor-patient relationship? Will the medical profession, once held in the highest public esteem, and in recent past eroded by the epidemic of malpractice suits, be compromised further by erosion of the confidential nature of the patient-physician relationship? With the security (perhaps mistakenly, to an extent) held by patients that they could consult a physician for disease or a psychotherapist or counselor for an emotional problem with the assurance of confidentiality gone, helping professions may never regain their position of the highest confidence and respect. These factors play major roles in both the prevention and amelioration of disease, whether the effect be called placebo, faith healing, or positive transference. If so, AIDS may not only destroy many persons, young and old, male and female, of diverse life styles, but its ultimate victim may be an essential ingredient of the health care system itself. Health care workers must face difficult decisions of conscience, as well as statutory law and the oxymoronic phrase "ethical

guidelines," as they attempt to serve both their patients and the larger society.

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Chapter 14

COPING WITH COUNTERTRANSFERENCE

Sheila Namir and Scott Sherman

Providing counseling or psychotherapy to people who have AIDS involves experiences that may be unique in the therapist's professional life. Whether these are seen as stressors, leading ultimately to "burnout," or as opportunities for both personal and professional growth, will often depend on one's awareness of countertransference issues evoked by working with people who have AIDS.

The concept of countertransference was used by Freud (1910) to refer to the influence of a client on the therapist's unconscious and was seen as a hindrance to effective work unless a therapist overcame it. Since then, the definition of countertransference has been greatly expanded. In 1950, Heimann enlarged the definition of countertransference to include all of the therapist's feelings and reactions toward the client. This "totalistic" view of countertransference (Kernberg, 1965) placed importance on the therapist's countertransference as a tool for his or her work, helping the therapist understand the client's dynamics (see Gorkin, 1987).

The expanded definition of countertransference, and its elaboration by other theorists and clinicians (Cohen, 1952; Little, 1951; Racker, 1957; Weigert, 1954), included an attempt to understand situations that led to the presence of anxiety in the therapist that could interfere with treatment. The potential of countertransference reactions to undermine or assist the therapeutic work is part of the "totalistic" approach.

Cohen (1952) described three broad categories that may contribute to countertransference and anxiety in therapists. These

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are situational factors, including competence and role issues for the therapist; unresolved neurotic problems of the therapist; and, the overwhelming feelings of the therapist when the client's anxiety is communicated to the therapist.

In this chapter, we will explore countertransference issues that arise in working with people who have AIDS or are positive for the HIV antibody. We will use the term countertransference to refer to the therapist's conscious and unconscious emotional reactions to clients and to the nature of the disease. Following an overview of the literature on countertransference reactions to people with life-threatening illnesses, we will explore issues that confront therapists in working with people with HIV infection or AIDS based on situational variables, therapist factors, and specific client variables. We will then address the common defenses therapists may employ against feelings and reactions aroused by these variables, and suggest ways to confront countertransference issues. By discussing some of these issues, we hope to help therapists recognize responses and feelings toward clients that may contribute to their own feelings of "burnout" or might prevent them from working effectively with people with AIDS.

Overview of the Literature

The literature on countertransference issues specifically with people who have life-threatening illnesses, or are dying, has often focused on whether or not therapists have confronted issues about death in their own lives (Burton, 1962; Clarke, 1981). Explicit in these discussions and studies is the hypothesis that if therapists have confronted these issues in their own lives, they would be better equipped to help others who are dying.

The intense reactions and painful feelings elicited by working with people who are dying are often discussed in books and articles for therapists about working with terminally ill persons (Bascom, 1984; Burton, 1962; Eissler, 1955; Pruyser, 1984; Rando, 1984; Remmeker, 1957; Sourkes, 1982; Weisman, 1981). These reactions result from the need for therapists to confront their own separations and losses, fears of illness, death and dying, and unconscious fantasies related to rescuing others from death (Eisendrath & Dunkel, 1979; Sourkes, 1982). An inability

or unwillingness to confront any of these reactions can lead to avoidance of clients, overidentification with them, unresolved repetitive grief reactions, or "chronic demoralization" (Pruyser, 1984), and "blaming the victim" (Ryan, 1971) in an attempt to deny or avoid one's own vulnerability or sense of personal failure in rescuing people from illness and death (Remmeker, 1957).

In addition to the above, the specific countertransference issues mentioned in the literature include threats to one's sense of power, mastery, and control (Rando, 1984), anger at the dependency needs of medically ill clients (Eisendrath & Dunkel, 1979), over- or underinvolvement, anxiety or depression, and false optimism (Weisman, 1981). We would also include survivor's guilt, subtle homophobia, overvaluing the importance of work with people with AIDS compared to other clients, overestimating or underestimating the seriousness of the disease, and avoidance or denial of discussion topics related to death and dying.

Working With AIDS Clients

The AIDS epidemic in this country has deeply affected counselors and therapists. Few of us have remained untouched by the need to struggle with our countertransference reactions, even if it is on the level of deciding whether or not to work with people who have AIDS. The epidemic has, more specifically, involved us in an existential crisis, a social crisis, and a professional crisis.

The existential crisis relates to our own understanding and beliefs about illness, death and dying, and the intense reactions to witnessing illness and death in so many young people in our country. This can lead to becoming increasingly demoralized, and adopting a tragic view of life. We fight to maintain hope and ward off despair, but the pain of the world is no longer an abstract philosophical idea (Pruyser, 1984).

A social crisis ensues when we become involved in fighting discrimination and negative attitudes toward those who have AIDS; when we become frustrated with legislative and political activities that threaten to harm those we are trying to help; when we confront issues of sexuality, sexual behavior change, and drug abuse; and finally, when we seek to empower disenfranchised members of our society.

The professional crisis may begin with our perceived or actual lack of adequate knowledge and competence in working with medically ill clients. We have to become educated about the complex medical and neuropsychological aspects of AIDS, in addition to the psychosocial aspects of illness, death, and dying. The professional crisis continues when we experience conflicts related to our role as professional counselors or therapists, and the intense demands and needs of people with AIDS. Our training in traditional psychotherapy may become a source of conflict for us as we struggle with the need to be available and responsive, as well as the need to provide support, advice, information, and advocacy for our clients. All of these crises may impede or assist us in our work with people with AIDS, depending on our abilities and willingness to struggle with the countertransference issues they elicit. In his or her work, each therapist needs to determine when unusual behavior and responses to clients may be due to countertransference. We will discuss these in terms of the situational, therapist, and client factors that may contribute to countertransference reactions.

Situational Factors

The nature of the disease is an important source of potential countertransference reactions. One of the hallmarks of AIDS is the relative unpredictability of the course of the illness, which can interfere with a therapist's desire to establish goals, maintain continuity, and feel effective. As a person with AIDS becomes more ill, increasingly physically debilitated, and possibly more depressed, it is more difficult for the therapist to intervene in effective and meaningful ways. Previous treatment goals and interventions may become meaningless or ineffective because of the changing condition of the client. These goals and interventions must be constantly reevaluated based on the client's current physical, emotional, and neuropsychological condition.

Another related issue confronting therapists working with persons with AIDS is the demand of new roles. These roles frequently generate anxiety and insecurity because they often mean that therapists must be in environments with which they are unfamiliar and in which they feel unsafe when compared to their own offices. When a person becomes ill it is quite likely that during the course of the illness he or she will be frequently hospitalized and at times will be too ill to travel to a therapist's

office. Therapists who work with clients with AIDS will often have to make hospital visits and home visits in order to continue their work with them. For many therapists, making home visits may feel like an invasion of privacy and a crossing of boundaries. Therapists must be able to explore what internal resistances they have to visiting clients in their homes or in the hospital.

Many people, including therapists, feel uncomfortable in hospital settings because of the preponderance of unfamiliar medical equipment, language, and procedures. Hospitals may also elicit associations with unpleasant experiences. Additionally, visiting a client in the hospital can generate increased anxiety because it is often there that a person with AIDS is the most vulnerable and where the impact of the illness can be seen most clearly. It is important that therapists explore their willingness to make hospital visits, which are time-consuming, and to understand and anticipate the kinds of anxiety and discomfort they may feel in a hospital room.

People with AIDS in therapy often ask medical questions, describe medical procedures and diseases, and ponder the meaning of various laboratory results. For nonmedical mental health professionals, these questions and discussions may generate anxiety as they become aware of their lack of knowledge and competency in these areas.

Therapists must also struggle with the "rules" they have assumed in their practice of psychotherapy. They need to struggle with decisions about giving advice, working with the extended family and friendship network, touching or hugging a client, the fees they charge, and educational interventions. Whether or not the standards of behavior or rules therapists have previously adopted are applicable to their work with people who have AIDS is a source of conflict for some therapists.

Therapists may find themselves in the position of being advocates for clients, as well as speaking and interacting with family members, significant others, and medical personnel. These situations raise issues of confidentiality, and often other ethical dilemmas. The lack of clearly defined confidentiality and ethical guidelines related to people with AIDS is a source of anxiety for therapists. Debates continue in different governmental legislatures, professional organizations, and committees regarding these guidelines or potential laws. A therapist may, however, become obsessed by these arguments, immobilized by the lack of clear guidelines, and fearful of what he or she says or does.

The unpredictable course of the disease, medical crises and treatments, changing treatment goals, interventions, and settings, as well as the demands these place on the therapist for assuming new roles and behaviors are situational variables contributing to countertransference issues. These, however, are intimately connected to therapists' own unresolved issues.

Therapist Factors

Perhaps the most salient issue that therapists working with persons with AIDS must confront is their own mortality. Most individuals do not confront the inevitability of their own death, but rather operate under a system of denial and invulnerability. However, when one works with persons with AIDS, and especially those clients who are near death, it is impossible to maintain one's sense of invulnerability, or to continue to deny the potential of one's own loss and the anxieties that losses often generate. Whenever a client dies, experiences and feelings associated with other losses in the therapist's life come to the fore. The extent to which these previous losses have been understood and resolved will affect the therapeutic relationship with the person who is dying. Every current loss experience necessitates a working through of previous losses and an acceptance of the necessity for allowing for a grief reaction for the person who has just died. The challenge the therapist faces is to confront his or her own feelings of attachment, sadness, anger, and depression related to both previous losses and the current loss.

Therapists place an emphasis on maintaining objectivity and professional distance. These values are stressed in training and in much of what is written about doing psychotherapy. However, therapists do form attachments and bonds with their clients. These feelings of attachment, care, and concern must be acknowledged and validated. Therapists who feel they have been unprofessional in becoming attached and caring for a client with AIDS run the risk of depression and burnout because they may end up feeling alone in their grief reaction. Our sense of our roles as professionals may also make it difficult for us to give ourselves permission to grieve or to participate in rituals that would help us to resolve our grief. The loss of a client often is not defined as an appropriate loss to be grieved, and we may struggle as we attempt to deny these feelings.

An equally important issue for a therapist to confront is: "What is my motivation for wanting to work with someone with AIDS?" Therapists must be clearly aware of what it is that they expect to gain from this work, as well as what is going to be expected of them as they embark on it. Is this a veiled way of working out their own issues of fear of AIDS? Are therapists seeking validation for their own magical thinking that they are immune from exposure to the AIDS virus by exploring how others may have been exposed to it? Is there the hope that they will confront their own fears about death, or work out their own past and potential losses? Is counseling the dying seen as an opportunity for noble, glorious, and profound experiences? One cannot automatically assume that issues of motivation and self-interest will not seep consciously and unconsciously into the therapeutic relationship.

Most of us entered the mental health field because we had a conscious need to help others. Whether or not this was a sublimation of feelings of magical omnipotence may affect our feelings of helplessness in working with people with AIDS. When faced with the barrage of medical symptoms, psychic and physical pain, intense fears and the wish for a cure, we may begin to feel that all our efforts do not make much difference. Our belief in the efficacy of our therapeutic skills, and therefore our therapeutic hope, may be diminished or destroyed.

For many of us, AIDS is not an issue solely in our professional lives, but it is also present in our personal lives. This unremitting focus on AIDS can contribute to feelings of being overwhelmed and overburdened. If we have engaged in behaviors that may place us at risk for having contracted the virus, we may suffer "survivor's guilt," wondering why our clients are ill and not we. If we have not engaged in risk behaviors, there may be an exacerbation of "blaming the victim," attempting to protect ourselves by moralistically attributing blame, thus reducing our capacity for compassion, empathy, and identification, and further stigmatizing people with AIDS.

Our unresolved role conflicts may also create problems in working with people who have AIDS. There may be a tendency to stay within a narrowly defined role, or to focus on professional knowledge and factual or philosophical issues. Ultimately, this is a way to withdraw from people with AIDS. On the other hand, for some of our more isolated clients, we may become their major source of support, leading to conflicts about the limits of our role and responsibilities we can assume.

Client Factors

The most obvious client variables that may contribute to countertransference reactions in therapists are the levels of fear, anxiety, despair, and hopelessness a person with AIDS experiences. We may become overwhelmed if the intensity and levels of any of these reactions are high. Therapists may react differently to clients who are optimistic, who minimize their distress, who avoid talking about having AIDS, or who use frank denial as a defense. It is important that therapists become aware of how these different responses to AIDS on the part of the client may be affecting them and the therapeutic work.

The client's own belief system about life and death may either be in conflict or be congruent with the therapist's belief system. Because of the central nature of these beliefs, the potential for countertransference reactions is strong. A client may seek religious, spiritual, or psychological experiences that the therapist may judge, thus damaging the therapeutic relationship.

Complicating the more general countertransference issues discussed above are difficulties in working with people who have a personality disorder or who may be considered "difficult clients" without the additional burden of being physically ill. Many of us wish to believe that being confronted with a life-threatening illness can help in the development of a positive spirit. We have seen how the crisis has helped some people with AIDS to develop stronger personalities and has given meaning to their lives (Mandel, 1986). These experiences may contribute to problems with those who do not conform to this belief. In fact, a physical illness can exacerbate underlying difficulties in living and coping, and can create profound countertransference issues for therapists (Groves, 1978; Namir & Wellisch, 1985). Groves's discussion of the types of "hateful client" and what they evoke in the therapist is particularly useful. He described four types of difficult clients who are also medically ill: dependent clingers, entitled demanders, manipulative help rejecters, and self-destructive deniers. Clingers evoke aversion, and therapists need to set limits before they become exhausted. Demanders evoke fear in therapists as they attempt to intimidate them through hostility and threats. A countertransference response to demanders may include counterattack. Help rejecters evoke guilt and feelings of inadequacy in the therapist, whereas deniers evoke all of the above negative feelings as well as anxiety on

the part of the therapist because of clients' self-destructive behaviors.

Illness can often cause a regression in people because they feel more dependent, fearful of abandonment, depressed, pessimistic, or angry. An added strain on the therapist may be the attempt to deny intense and hateful feelings toward the difficult client. If therapists are to avoid maladaptive solutions to their countertransference, including unconscious punishment or avoidance of the client, responding in an empathic way will be important to determine what is caused by the illness or by fears and justifiable anger, and what is exacerbated by personality disorders.

Therapists commonly feel guilty for harboring negative feelings toward someone who is ill or dying. They do not feel justified in setting limits or confronting inappropriate and destructive anger. They may internalize the hopelessness and helplessness that these clients feel (Adler, 1972), making them ineffective in their work. Attempting to repress the negative feelings these clients evoke can lead to restlessness, anxiety, and impatience (Maltsberger & Buie, 1974). It is essential that the therapist recognize these reactions, and then become able, eventually, to help the client see how his or her behavior affects other people in ways that make it less likely that they will receive positive responses. A crucial variable in helping clients with AIDS to cope and live with their illness will be helping them to direct their anger in ways that are not self-defeating in order not to alienate medical personnel and their support networks.

Defenses Resulting From Countertransference Issues

The range of painful and difficult emotions engendered in the therapist working with someone with AIDS may create the need for reliance on measures that are protective in the therapeutic encounter. The most general protective device is to adhere to a theory about the nature of counseling the dying. Both empirical research (Lindemann, 1944), as well as clinical studies (Essler, 1955; Kübler-Ross, 1969), have led to the development of a number of models that put forth a stage theory of death and dying. These theories identify stages and processes that those with terminal illnesses move through. They relate, as well, to the process of grieving the loss of someone who dies. Two methods therapists have of protecting themselves from

the range of painful emotions is to rely exclusively on a prescribed model of working with a person with AIDS, and to try to work with a client on each stage sequentially. However, the rigid adherence to any model prevents therapists from being able to be supportive and available to the person with AIDS in a way that is more meaningful and responsive to the individual. In addition, the adherence to these models can engender in therapists increased feelings of failure and ineffectiveness if clients do not progress smoothly through the sequence of stages.

In order to minimize the painful awareness of their own mortality, and to reduce the anxiety associated with death, therapists sometimes unconsciously engage in such dangerous activities as minimization. They may minimize the seriousness of both medical symptoms and psychological distress, colluding with clients' own needs to avoid confronting these issues. They may not support or actively discourage individuals from dealing with painful topics such as writing wills, saying goodbye to significant others, or making plans for a funeral. Even more dangerous is when a therapist's anxiety results in missing subtle communications from a client about suicidal ideations, despair, or withdrawal from their usual activities.

Overreaction may be another defense to the therapist's own anxiety when confronting issues of mortality. This may be manifested in a therapist's unnecessary alarm over a report of medical symptoms, or more critically, his or her inability to maintain availability for clients when their medical status worsens. As a defense against feeling loss, a therapist may begin avoiding a client as he or she becomes more ill, rationalizing that "therapy" cannot be done during these periods.

In fact, when we begin to work with someone who is diagnosed with AIDS, there is a danger of maintaining an even greater professional distance and detachment than we usually maintain. Though we may feel that this is professionally correct, it is possible that it is related to our fear of becoming attached to someone who may die. Much of our work is through a painful therapeutic identification. It may be more difficult to do this with people who have a life-threatening illness. We may stop the investment of ourselves because, instinctively, we do not want to lend ourselves to dying through identification.

Persons with AIDS have often had the experience of significant others withdrawing from them, rejecting them, or generally being critical and negative, whether based on judgments about the illness or fear of the illness and contagion. The ther-

apist who is afraid of loss or who believes it is professionally correct to stay distant and detached mirrors that same reaction in the therapeutic relationship.

Our own vulnerability in the face of losses, our feared losses, and existential anxiety about the nature of life and death may also mitigate against feeling hopeful in our work. This can lead, at the worst, to depression, phobic reactions, and burnout. On the other hand, we may continue trying to make a difference, and become compulsive and driven about our work—forgetting to balance life and living with death and dying. There is a tendency to feel that all else pales in front of issues of dying and death, so we continue to work even when we are overloaded and stressed.

As with more general issues of countertransference, any unusual response to a client may be a clue to our anxious or defensive involvement with that client. It is, perhaps, easier rationally to justify these defenses when working with someone who has AIDS. However, these unexamined defenses will inhibit or harm our therapeutic work with clients, whereas an understanding and exploration of these defenses may help us both to work more effectively and to understand what our clients may be experiencing.

Suggestions for Confronting Countertransference Issues and Preventing Burnout

Many of our suggestions have been implicit in the discussions of both factors influencing countertransference and the defenses therapists use. Most importantly, therapists must remain cognizant of the extra demands, stresses, and personal reactions they will encounter in working with persons with AIDS, especially those who are approaching death. Therapists must consistently and carefully monitor their motivations for working with people with AIDS, their stress levels, and emotional reactions to the work. Especially common may be denial or overidentification, both reactions leading to ineffective and possibly harmful therapeutic interventions.

It is important for us to make the distinction between being ineffective as therapists, and the realistic helplessness we all may feel in the face of death. We need to explore our own feelings about illness, dying and death, and our beliefs about the goals

of therapeutic interventions in these situations. We may not be able to prevent someone from dying, but we may be able to help them feel less alone and misunderstood in that process.

Therapists who experience sadness and the pain of grief when a person with whom they are working dies need to validate these feelings and accept them as legitimate and appropriate. They must also find effective measures for coping with their own grief. It is important for people who work with AIDS to understand that experiencing grief and loss is not a failure of the therapeutic relationship, nor is it crossing over a professional boundary; rather it is a reflection of having had a genuine and real relationship with the person who is entering the final stages of his or her life. As such, it is not unusual for a therapist to want to attend a funeral or memorial service for someone who has died. This is not a reflection of overattachment or boundary-blurring, but rather may be a necessary step to validate a therapist's legitimate sense of loss. It is, however, not the only way to attain a sense of closure about people with whom therapists have worked who have died. What is important is that each therapist find a way to mourn his or her losses.

Therapists need to know when and with whom they can and cannot work without sacrificing their own quality of life. They may need to limit the number of clients with AIDS that they have in their case load at any one time. There may also be times that a therapist needs to accept that the work has become too difficult or painful, and not blame her- or himself or experience this as a professional failure. Rather, it may be a natural consequence of working in an area that constantly demands the experience of working through pain and loss.

Especially important to those working with persons with AIDS is the support and consultation of others doing similar work. Not only will this allow for the sharing of personal experiences, but may help facilitate identifying countertransference reactions of which the therapist is unaware.

Conclusion

We want to conclude this chapter with a personal statement by each of us about our work in this area. We hope that these statements will help illustrate some of the countertransference issues we have discussed above, and the ways we have attempted to work with or resolve these issues.

Scott Sherman: Reflecting upon my own experience and professional development in working with people who have AIDS, two experiences that clearly represent countertransference issues for me come to mind from the beginning of the work. The first was leading a therapy group, as part of a research project, with 12 men who had AIDS. Following the group they were asked to fill out some forms. Many of the men did not have pens. I happily loaned out mine for them to use. After everyone had finished and left the room, I was left with the pen several men with AIDS had used, and did not know what to do with it. I threw the pen out, fearful of even touching it. I realize now that I was overwhelmed by the experience of so many ill, dying men, who were not very different from myself, at a time when there was little hope of any treatment. In my anxiety about having to deal with issues and fears about death and dying, I could not touch them—either physically or emotionally—not even a pen they had touched. Thinking about my own fears, and my embarrassment at my own behavior, helped me to begin to examine what I would need to confront if I were going to be able to provide anything resembling therapy to these men. I am pleased that I found the support of colleagues at that time so that I am now able to hug someone with AIDS when it is needed, or to be with someone who is dying in the hospital, or simply hold someone's hand or stroke someone's arms to make sure the person knows and experiences my presence.

The second experience involved a man in his 30s, whom I had been seeing for 5 years in twice-weekly dynamic therapy. Around the same time as the group project, this man became ill with a rather aggressive form of lymphoma. We attempted to continue his treatment while he was in the hospital. He was convinced chemotherapy would wipe out his cancer, and the issue of AIDS was denied. "This is not AIDS. I have cancer" was his message. As he became more and more ill, and the cancer did not respond to chemotherapy, the doctors spoke with him directly about his condition, about AIDS, and about his poor prognosis. The client would then say to me things that clearly distorted what he had been told, and firmly denied his condition. I felt confused and wondered how to best work through this denial. For weeks, as his condition deteriorated, I walked a thin line between supporting his denial and confronting the issue of his certain death: it was excruciating to me. Finally, out of frustration stemming from all I had read about the stages

of dying, I sought consultation. I felt I was clearly failing this man after 5 years of work. I felt too close to him and too upset by his illness to help him come to terms with his death. In the consultation I was told, "Maybe he just can't say goodbye, and that is all right." I finally understood that my failure was in not allowing him to be where he was, and in not respecting and supporting what part, if any, of the "work" he could do. I began to feel free to be with him and allow him to decide how he would leave me, his family, and his friends. I believe that he truly appreciated my support. I and he went into a coma and died 2 days later; he believed he could beat his illness and that he did not have AIDS. This man's illness and death were powerful lessons for me, teaching me to respect and value the infinite number of ways people deal with their own death.

The impact of AIDS on me personally and professionally has been immense, and, at times, overwhelming. I have felt sadness as I watched vital, energetic men begin to wither away. I have felt pride seeing clients demonstrate courage, humor, and peace in the face of death and physical and emotional pain. I have feared for my health. This has been especially true when a client has had dementia or organic brain syndrome. I knew I would hate that type of illness the most, and would not want others to have to endure the pain of watching that process. I have feared for those I love, wondering if I could be there for them, or if they could be there for me. I have felt intense rage at the slowness of the government's response and at the total ignorance and bigotry of some people.

I have been challenged to find words of comfort for grieving lovers, mothers, family members, and friends, and have often doubted whether any words could bring comfort. I have received notes about the comfort I have been able to offer, and wondered what I had said, so that I could draw upon those words the next time. Finally, I do not remember a word, reminding me that there is no formula.

Certainly, as simple as it sounds, working with people who have AIDS has helped me to think more carefully about my life, my choices, and my priorities. I value my time and guard it. I am more able to say no to professional opportunities, and set limits with myself, giving myself more personal time for being with the people I love. Mostly, I feel grateful that I have allowed people with AIDS to touch my life, as painful as that is at times. They have taught me much about grace, courage, and living.

Sheila Namir: I have been providing consultation and therapy to people with life-threatening illnesses for the past 7 years. In thinking about the impact of this work on my personal and professional life, I began to realize that I have gone through different periods in the process. At the beginning, I believe that I was counterphobic in my approach. Somehow, I magically believed that if I worked with people who were dying, I would be able to come to terms with fears about people I loved or my own potential for becoming ill or dying. There must also have been some unconscious belief that by contributing in this way, I, and those I cared about, would be protected from illness or dying.

As the work intensified, and I began to struggle with my own reactions to clients, I became overwhelmed by the grief I was feeling and unable to express. I remember a young woman with whom I felt particularly close and identified with because of similarities between us. She died while I was with her, and as I walked down 10 flights of stairs crying, only to emerge back into the hospital contained and professional, I realized that I had no way to integrate my human grief reactions into my ideas about my professional role. I remember, also, trying to talk to a supervisor about countertransference issues that were emerging in my work, and being handed an article to read. He clearly gave me the message that we were not to discuss these feelings, and that, as a professional, I could find all the help I needed in the literature.

There were periods during these first years when I felt despair and anger. Although at times I felt ineffective because of these feelings, I began to try to direct them into actions. I remember one client saying to me that if physicians couldn't cure him, they could at least treat him humanely. I began to work with physicians and nurses to help them deal with their own feelings that, I felt, must be preventing them from showing the compassion they experienced. I also became active in directing my anger at decision makers at various levels of government.

I watched myself use denial. When one of my clients was diagnosed with cancer I kept minimizing it, saying to myself that she would be fine, that it wasn't a serious cancer. I even watched myself blame her for having symptoms for several months and not telling me or going to see a physician. I blamed myself for not having dealt earlier and more effectively with her difficulty in expressing feelings, or for not noticing that she

had lost some weight. I wanted to avoid her, believing that I could no longer work with her if she had cancer (we had been engaged in psychodynamic psychotherapy before her diagnosis). I was finally able to be fully available to her during her struggle with cancer after I began to recognize how shocking it was for me that someone in my private practice had developed a life-threatening illness, while I worked with people with AIDS in another setting (probably in the hope that I could isolate that part of life), and began to explore the countertransference issues, grapple with the professional role, and therapeutic decisions.

Then there was the bargaining that sometimes occurred. I remember that I placed a lot of my hope in one man who had AIDS. I believed he would live and that he would confirm for me my belief that this was not a universally fatal disease. I began to recognize that I was saying to myself, "I won't be able to bear it if he dies too." I recognized my countertransference when, after a particularly lively session with him, I began to imagine what I would say about him in eulogy, and realized the defensive aspect of this fantasy.

There are the funerals I went to, not knowing where to sit. I was not really friend or family. You can often tell who the therapist is at a funeral—she or he will be sitting alone in a pew in the back.

There were times that I couldn't go to the hospital, that I felt if one more person died I would not be able to continue this work, that the demands from clients, physicians, and friends were encroaching on the quality of my life.

I began to be intolerant of the daily demands, the ordinary problems in living, the neuroses of my clients. This was a phase where all else paled in the face of the trauma of a life-threatening illness. It also coincided with my intolerance of my own problems and pleasures—refusing to pay attention to my needs or feeling guilty if I enjoyed myself while my clients were suffering.

Eventually, by carefully exploring my reactions and the ways this work was affecting my life, I regained some perspective and balance in both my work and my personal life. I began to feel grateful and privileged to be allowed to do this work. Today I continue to learn from my clients about the meaning of life and of death and to confront my own beliefs more directly. I continue to be moved by the courage, integrity, and love I see in working with families, friends, and lovers of people

with AIDS, as well as those struggling to live with AIDS. There are constant reminders to myself about what is really important and about the need to keep my priorities clear.

Eissler (1955, p. 245) asked, "Which is really harder—to die or to witness death?" I can't answer that, having experienced only the latter. But I can say that to witness is to participate, and to be forever changed by it.

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